Hearing Services Program Review 2020
Submission related to Consultation Paper 30 October 2020

Firstly, congratulations on the breadth and overall aims of the Review. You are posing the right questions. It has the potential to make a real difference to the quality of hearing care delivered under the Hearing Services Program. Because of the dominance of the Program on hearing care delivery in Australia, it also has the potential to "lift the game" of the entire sector.
The previous consultations and reports referenced by the Consultation Paper adequately describe the many dimensions and costs of the burden of disease caused by loss of hearing, and the cost/benefit relationship of successful (re)-habilitation.
Our submission is founded on more than eighty years combined experience as audiologists delivering hearing care, and over sixty years combined experience in measuring outcomes actually obtained by consumers of hearing care. Our interest in making this submission stems from our frustration with the past focus on input processes, rather than delivery of outcomes desired by clients and funders of hearing care services. We have only addressed the discussion points where we have relevant experience and supportive data.
(Disclaimer: We are both directors of [redacted], an outcomes measurement system that has collected data on private and Government-funded hearing care in Australia and overseas since 2001. [redacted] was developed as an outcomes-based solution to problems we saw in the industry as a whole.)

The field of hearing care has some unusual features which need to be considered in Program design and operation.

- Hearing aid technology and device models are constantly evolving, with manufacturer-generated terms related to features. This makes informed comparison and informed consumer choice problematic.
- The rapid rate of change in devices means that academic research results for particular design features are usually published *after* that feature has been extensively changed or even abandoned.
- Repeated research has shown that the target population for hearing care has a large proportion of "non-seekers" who believe that hearing aids "don't work". [1,2] The fact that only 33% of those with hearing loss are accessing services reflects the poor reputation for effectiveness of hearing care. ("Hearing aids don't work"). If the "burden of disease" is to be reduced, the 67% who do not seek care and continue to experience the communication problems caused by their loss of hearing should also be considered. (In comparison, consumers have a high level of confidence when seeking care for visual impairment – very few wait until their vision problems are so bad they lose their driving licence, or can no longer read. On average, people with hearing loss (and their families) endure the consequences of deteriorating communication for at least 10 years before seeking help.)
- If treatment effectiveness could be improved with the operation of a more responsible outcomes-focussed Program, uptake of hearing care would follow. This "grows the pie" for all stakeholders (consumers, providers, manufacturers), and reduces the flow-on costs of untreated hearing loss.

- [redacted] experience measuring hearing aid outcomes shows that client satisfaction with (or lack of) benefit following fitting is attributed to the device, not the clinician. This is probably the source of the belief noted in the previous point.
- Analysis of thousands of client outcomes has shown that the dominant factor in determining a successful outcome in hearing care is the work of the clinician. The wide range of outcomes across clinics indicates inconsistent performance of the industry as a whole, including the Program. (See below. Figure 1. Distribution of average satisfaction scores across clinics.)
- Program improvement should require monitoring and management of outcomes delivered by clinicians. At present, service providers are monitored against the standards of the contract, but not their outcomes. This "tick the box" approach does not guarantee consistent outcomes. and is not the hallmark of a quality program.
- Because clients are reluctant to consider their clinician as a source of problems, outcomes measurement should be ostensibly focussed on device performance. Has the fitting met the communication needs of the individual? "Fitting" includes not only the device, but also the counselling and rehabilitation processes used to support the beneficial use of the device, within the framework of the individual needs of each client.
- A "League Table" of provider performance would enable consumers to have informed choice, rather than relying on either anecdotal reports or commercial marketing.

Discussion Issues

1. What should be the objectives and scope of the Program? The Program objectives should explicitly mention a quality target managed by the Program. It is not sufficient to have an *accessible* program, and to count the number of services provided and the number of devices fitted, as is the current situation. The objective should be to have *effective* services (including devices worn with significant benefit) if the "burden of disease" is to be reduced.

2. Which consumers should be eligible for Program subsidies? Discussion of eligibility for the Program should recognise the profound effect that the Program has on the wider population. It is estimated that fully or partially subsidised hearing services account for approximately 87% of hearing devices fit in Australia. If a more responsible and effective Program was developed, the possibility of extending Government subsidised hearing care to the 13% of Australians currently self-funding their hearing care could be considered. There are also those who desperately need hearing care who are not eligible for Government funded services and cannot self-fund their hearing care needs who "fall through the cracks" (e.g. low income earners, refugees).

3. How well does the Program interface with other schemes? As mentioned above, the variety in performance of different providers warrants attention as a quality and

equity issue. The message to consumers is that if a business is an "approved Government provider", that this constitutes some form of assurance that the provider is able to deliver the quality of care required. Information provided with vouchers implies that all providers are equal – that is, that a client of the Program will get the same quality of outcome regardless of which provider they choose. This is not the case (see Figure 1).

4. Does the Program sufficiently support hearing loss prevention? No comment

5. Are the Program's assessment and rehabilitation services meeting consumer needs? The balance between device and service is problematic at present because the commercial reality for all providers is dominated by device fitting, especially for more expensive devices. There is a tendency to focus on fitting the device, rather than supporting the effective use of the device to minimise communication problems. This latter service takes time when responding to the individual needs of the client, but providers report that such time is not compensated in the current funding model. Attempts at correcting this by enhancements of the Program such as "Rehab Plus" have not had good take up because there is no focus on rewarding successful outcomes. In addition, [redacted] data shows that Program clients with Free-to-client (FTC) devices are more satisfied with outcomes than clients with "Top up" devices. Consequently, measuring and reporting whole of clinic outcomes could encourage providers to better fit FTC devices. Equally importantly, clinicians would be discouraged from "over-promising and under-delivering" expected outcomes, as well as from fitting devices that are unlikely to be used (e.g. to poorly motivated clients).

6. Is the Program supportive of consumer choice and control? At present, the Program is only supportive of consumer choice in that it provides a list of service providers in the consumer's local area. There is no information about which of those services providers is achieving the best outcomes, because the Program does not collect this information. So informed consumer choice is not a feature of the Program. This then leads to considerable difficulty if the consumer is not satisfied with their outcome. The reality is (a) there is a very low level of complaint, and (b) the consumer often gives up ("hearing aids in the drawer") or endures a lower quality outcome in the belief that is all they can expect. In regard to consumer choice of devices, the reality of the industry is that each clinic is either tied to a single supplier or works with a limited set of suppliers. (You can't expect to buy a Hyundai if you go to a Rolls Royce dealer.) It is unrealistic to hope that consumers can intelligently choose between the hundreds of devices available, or even that a single provider can make intelligent discriminations between them, let alone fit them optimally . However, a quality monitoring system should encourage providers to make good decisions on behalf of the client, and (maybe) occasionally refer them away to another provider who could better meet the client's needs.

CSO provision could be enhanced in rural/remote areas by a resident private provider who can "make a living" through offering CSO, Voucher, and private services. Additionally, some private clients "graduate" to CSO eligibility and should be able to continue with their original provider (provided that provider is part of the Program.) [redacted] has collaborated with consumer organisations ([redacted]) to explore ways in which meaningful information can be presented to consumers to help make informed decisions about their hearing care.

7. Are the Program's service delivery models making best use of technological developments and services? One example of the introduction new technology occurred some years ago when Blamey/Saunders offered computer aided self-assessment and hearing aid fitting. For a sophisticated group of users (especially in remote areas) this was very appropriate but was not offered through the Program. This example demonstrates how technology will continue to run ahead of proscriptive rules governing the Program. It is envisaged we will see other examples in the future. "Future-proofing" the Program will require intelligent design, with a light touch on the "thou shalt not" pedal. Changing the focus of the Program to be more outcomes-based would avoid potential problems of easing restrictions.

8. Does the Program sufficiently support consumers in thin markets? As mentioned in point 6, thin markets may offer opportunities for providers with a specific set of attributes, for example-

    a. language skills (including Auslan)
    b. remote location
    c. semi-retirement (allowing low income operation)
    d. cultural / ethnic background

9. Are there opportunities to improve administration of the Program? In common with many areas of Government and private sector supply, quality management is difficult. Audit processes need to be tied very closely to the desired aims of the Program, rather than the minutiae of "tick the box" processes. At present, service providers are audited against their compliance with contract conditions. Not only is this is expensive (in manpower and cost – at one stage there were 200 OHS staff administering 300 contractors), but it has proven to be ineffective in monitoring quality. Compliance with the contract is no guarantee that satisfactory outcomes are being consistently delivered. There could be significant cost-savings to the Program if there was an outcomes-based requirement. Audit activity could be focussed on providers with poor treatment effectiveness (e.g. high rates of non-use of devices, or low satisfaction levels with benefit from the delivery of services). Providers with high quality outcomes are most likely complying with contract conditions, as well as delivering outcomes that meet the aims of the Program. Audit processes can be

simplified by auditing against fraudulent activity, rather than compliance with the wider requirements of the contract.

Example: One experienced provider in a large city in [redacted] was consistently delivering outstanding outcomes, as validated by [redacted] over many years. He withdrew from the Program when [redacted] auditors refused to examine this performance data, instead concentrating on a small number of minor issues around record-keeping.

10. **Does the Program effectively make use of data and information to inform decision-making?** As stated, the Program has a transaction-level view of the services delivered. The Program can only *assume* that these transactions will reduce the burden of disease. It does not, and cannot, report on Program effectiveness or quality. Moving to an outcomes measurement system across the Program would provide –

    - Validation that the Program is meeting the desired aims of reducing the burden of disease.
    - Reassurance for consumers about treatment effectiveness.
    - Accountability for continued Government funding of the Program.
    - An evidence base to inform broad and detailed policy.
    - Relevant information to guide informed consumer choice.
    - A saleable product for outside researchers including device manufacturers.
    - The potential for detailed benchmarking reports that can be used by providers for staff management and training (leading to quality improvement in the industry.)

We are seeking to support this submission by meeting with the Review Panel.

Once again, we commend the Review Panel for their attention to the purpose of the Program.

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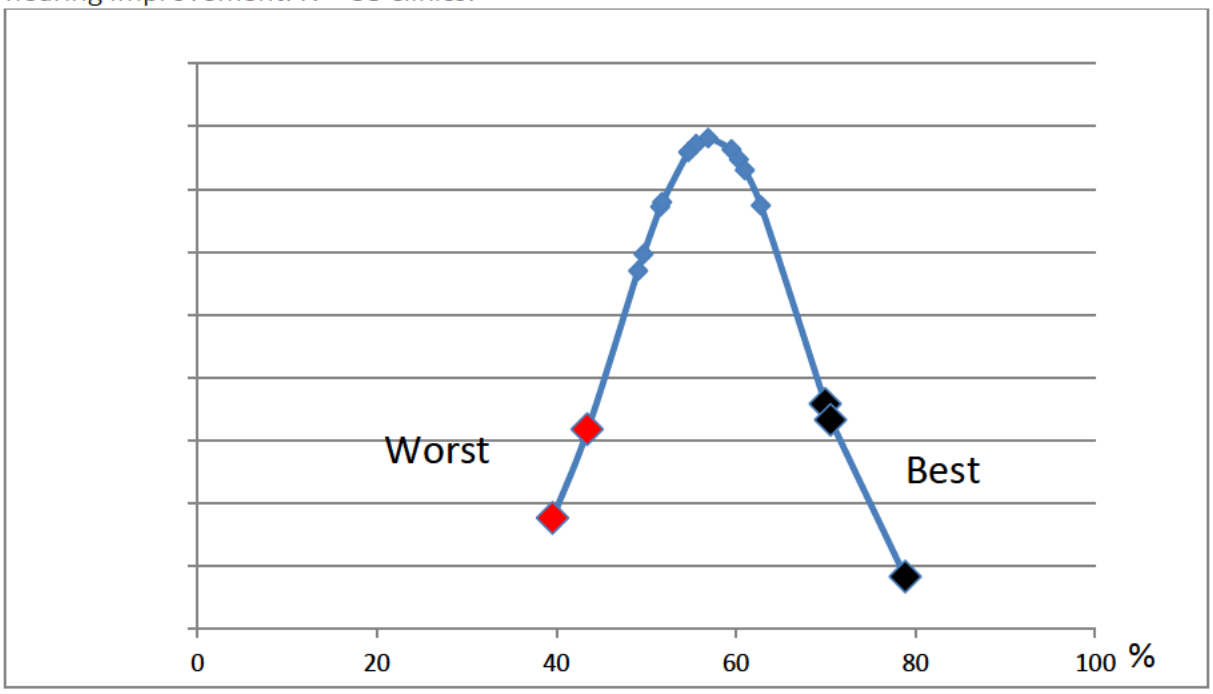
Figure 1: Distribution of clinic average percentage scores for consumer satisfaction with hearing improvement. N = 53 clinics.



NB: A clinic score of 100% would mean all clients of that clinic were satisfied with their hearing in all their relevant listening environments. The range of scores in this group varied from 37 – 80%, with the average just under 60% for the group.

This variation across clinics has been further verified by a current research collaboration between EARtrak and NAL. Examining performance across 65 clinics, mean satisfaction with hearing improvement was 65.7%, with a range from 54.1 – 79.0%.

References:

1. Kochkin S MarkeTrak III "Why 20 million in US don't use hearing aids for their hearing loss." *The Hearing Journal* 1993; 46(1):20-27
2. Hickson L "Improving rehabilitation for adults with hearing impairment: Asking and answering some big questions." Denis Byrne Memorial Lecture, Audiological Society of Australia National Conference 2010